DOCUMENT RESUME

ED 261 314 CG 018 512

AUTHOR Henry, Phil; Morse, Maria
TITLE Teenage Suicide: The Final Cry.
INSTITUTION Governor's Advocacy Council on Children and Youth, Raleigh, NC.
PUB DATE May 85
NOTE 49p.; Appendix B is marginally reproducible because of small print.
PUB TYPE Reports - Research/Technical (143) -- Tests/Evaluation Instruments (160)

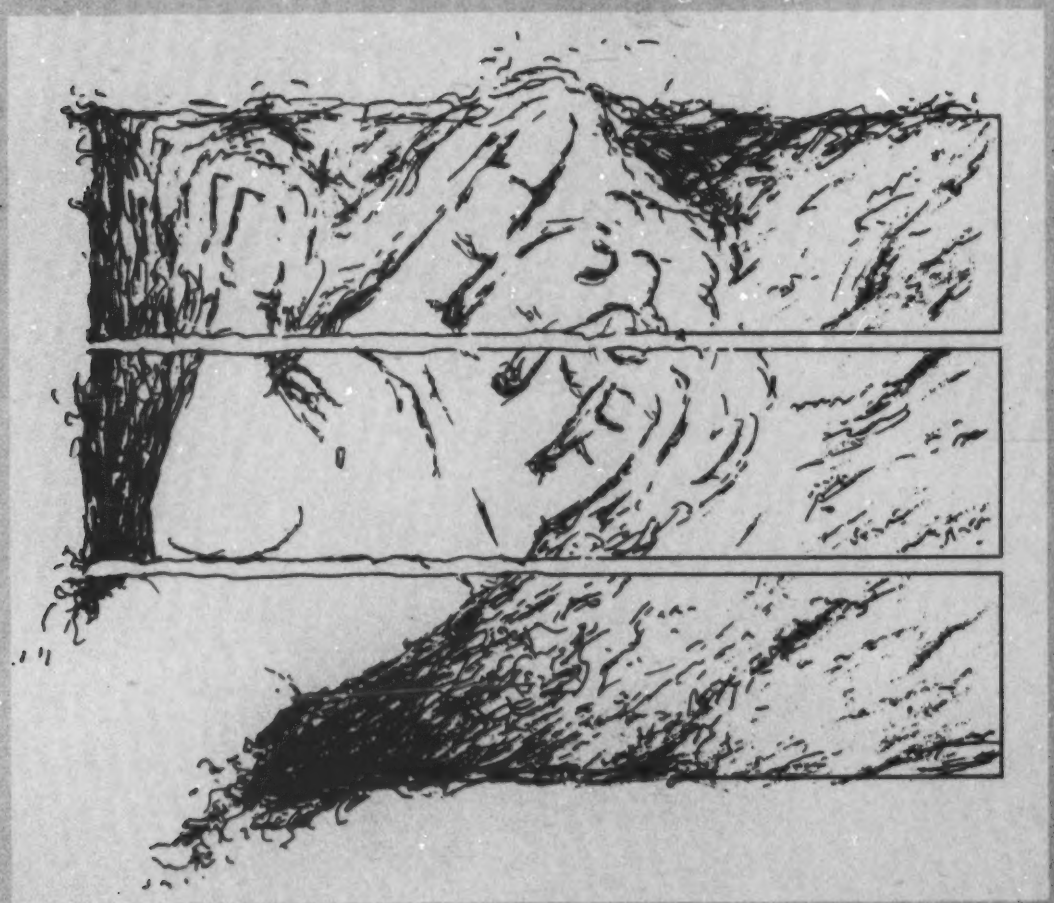
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Adolescents; *Crisis Intervention; Financial Support; *Mental Health Programs; *Prevention; Psychological Services; *Suicide
IDENTIFIERS North Carolina

ABSTRACT

To learn more about the services available to youth at suicide prevention centers in North Carolina, a survey was conducted with 86 mental health and crisis prevention centers. The 16-item questionnaire examined the availability and extent of services offered by the centers, staffing patterns, sources of funding, and percentage of clientele between the ages of 13 and 24. The results indicated that centers received their funding from federal, state, and local governments; church groups; charitable organizations; or individuals. One facility dedicated 100 percent of its time to suicide prevention/intervention. For other centers the percentage of their services related to suicide prevention ranged from less than 5 percent to 50 percent. Although most centers reported having 24-hour service, other services such as hotlines, referral systems, crisis intervention, crisis housing, medical care, walk-in services, and special programs for adolescents varied extensively among centers. Staffing patterns and the percentage of youth served were both dictated by the size, purpose, and orientation of the facilities. This report contains an executive summary, research findings, statistics, and warning signs of potential teenage suicide. The survey questionnaire is included in the appendices and data tables are provided on national and state suicide statistics. The 86 mental health centers in the survey are listed in table form with center name, address, telephone number, counties served, hours, services offered, and other information given for each center. (NRB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

BEST COPY AVAILABLE



ED261314

CG018512

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Philip N. Henry

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

TEENAGE SUICIDE

THE FINAL CRY

Governor's Advocacy Council on Children and Youth - May 1985

TEENAGE SUICIDE: THE FINAL CRY

Governor's Advocacy Council on Children and Youth
Youth Advocacy and Involvement Office
N.C. Department of Administration
121 West Jones Street
Raleigh, North Carolina 27603-1334

(919) 733-9296

May 1985

CS 018512

PREFACE

"Why did my son take his life?"

"What were the reasons our classmate could no longer cope?"

These are questions typically asked by those individuals left behind after a suicide. Many suffer from the devastation of teen suicide.

When a young person takes his or her own life, we all have to wonder why. "Teenage Suicide: The Final Cry" is an attempt to answer some of the "why's."

The Governor's Advocacy Council on Children and Youth wishes to thank the two people most responsible for this report: Maria Morse, student intern and principal researcher, and Dr. Phil Henry, staff to the council and principal author of the report. Basing their work on survey results and extensive literature searches, these two have given us a timely and informative report.

It is our hope that this report and the recommendations offered herein will be the first concerted effort by our state to begin addressing the growing problem of teenage suicide. We have a challenge and a responsibility to listen to our troubled youth and hear their cries for help. We cannot afford to wait for the final cry.

Herb Stout, Chair
Governor's Advocacy Council on
Children and Youth
May 1985

TABLE OF CONTENTS

Executive Summary 7
Background 7
Recommendations 8
Further Study Needed 9

Overview 10

Efforts to Curb Suicide Rate 11

What Research Reveals About Teenage Suicide 13

Myths Regarding Teenage Suicide 16

Warning Signs 17

Statistics on Teenage Suicide 19

Survey of Suicide-Prevention Services in North Carolina 24
Procedure 24
Results 24
Discussion 37
Conclusion 38

Notes 40

Bibliography 42

Appendices 45
Appendix A 45
Appendix B 48
Appendix C 49

Tables 19
I. Death Due to Suicide in U.S. (ages 15-24) 19
II. Nationwide Suicide Statistics (ages 10-24) 20
III. Suicides, North Carolina, 1970-1983.....22
IV. Suicides, North Carolina by Race and Sex.....23
V. Suicide-Prevention Services in North Carolina 25

EXECUTIVE SUMMARY

Background

"Teenage Suicide: The Final Cry" is a report of the Governor's Advocacy Council on Children and Youth (GACCY) that gives an introspection into one of the most baffling calamities of our time, adolescent suicide. Each year since 1977, some 5,000 young people in this country between the ages of 15 and 24 have uttered their final cry, and the resounding echo has shattered the myth of the carefree happy-go-lucky period called adolescence.[1] This is not a pleasant time for many who fall victim to the many forces which imperil the very fabric of our society.

Besides withstanding the physical and psychological tensions associated with this period of development, teenagers today must cope with an unprecedented divorce rate, rampant sexual promiscuity, easy access to drugs and alcohol and a breakdown in family values, and still strive to make good grades in school and be successful in a career. For some these pressures appear unrelenting, and as their coping mechanisms shatter they scream out for help, hoping that someone is listening. To them suicide appears to be the final way out.

Experts are perplexed by the continuous rise in teenage suicide. Since 1950 suicide among adolescents has increased nearly 300 percent in the United States. It is now the second leading cause of death among the 15 to 24 age group. In North Carolina, from 1980 to 1983 an average of 130 adolescents committed suicide each year.[2] Predictions are that these statistics are likely to remain high.

At the same time an atmosphere of hope is growing in many communities which is more sympathetic and conducive to the needs of youth. Suicide-prevention efforts have taken on many appearances, from suicide hotlines to courses in the school curriculum. Many schools offer workshops on prevention for teachers, parents and students. Awareness of the warning signs and where to find help are believed to be the surest keys to curtailing the alarming suicide rate.

Survey Findings

In an effort to learn more about the services offered to young people by suicide-prevention centers in North Carolina, the Governor's Advocacy Council on Children and Youth surveyed 150 mental health and crisis-prevention centers. Almost all of the survey respondents offered 24-hour services and 60 percent had hotlines.

Twenty-five percent indicated a cut in funds earmarked for services, and around half of the respondents answered that five percent or less of their services were suicide-related. Of concern was the lack of crisis housing and special programs for adolescents. Overall, the data shows that services are in place to deal with suicidal behavior. However, this research was unable to reveal the adequacy of services or whether teenagers and their parents are aware of the extent of services and how to get help.

The present report highlights the many problems associated with teen suicide and the responses of parents, teachers, mental health professionals and government. A directory of the facilities responding to the survey is included in Table V as a resource. The Governor's Advocacy Council on Children and Youth hopes that this report will shed some light on the problem and direct readers to search for solutions.

Teenage suicide is everyone's business. We must all be attentive by observing and listening for the first cry. For the final cry is fatal and it leaves us with only a deafening echo and more questions.

Recommendations

The North Carolina Department of Human Resources in coordination with private suicide-prevention centers should

Develop training materials on suicide prevention to be used by mental health professionals and non-professionals (parents, teachers, youth services workers, doctors, law enforcement, etc.)

Develop and initiate standards to be used by centers in regard to organization, staffing, training, ethics, services and program evaluation.

Develop and initiate a mechanism to train and employ teenage crisis counselors and other concerned volunteers to staff hotlines and crisis centers.

Plan and facilitate community workshops throughout the state to make the public aware of the problem of teenage suicide and how it can be prevented.

Develop and initiate a publicity campaign to make teenagers and parents aware of services in the community and at the state level to serve their mental health needs.

Encourage the development of special programs within the mental health community to focus on the problems and concerns of adolescents.

The Department of Public Instruction with the assistance of the Department of Human Resources and private suicide-prevention centers should

Initiate training workshops on suicide prevention for all primary and secondary school counselors.

Initiate training workshops for teachers with an emphasis on observation and how to detect masked depression in students.

Incorporate in the curriculum for junior high and high school students lessons in coping skills to include self-esteem building, communication skills, positive failure and handling grief.

Incorporate in the curriculum plan a component on stress management and how to help a friend in crisis.

Publish and make available information on suicide prevention in school libraries, counseling centers, student lounges and nurses' stations.

Distribute suicide-prevention information to parent-teacher organization members and encourage them to participate in prevention programs.

Develop a plan of action to be used in case of a suicide or attempted suicide; encourage schools to form crisis teams which should include teenagers to work with students, parents and teachers.

Further Study Needed

1. Research to see how much coordination, if any, exists among the various suicide-prevention centers in the state. (is a state plan needed?)

2. Research on the effectiveness of the publicity methods used by centers. (Do young people know what services are available and how to contact the appropriate persons?)

3. Research to determine if there is a relationship between child abuse and suicidal behavior.

4. Research on the method and effectiveness of monitoring suicidal youth in institutions.

5. Research to determine to what extent factors such as insurance policies influence medical examiners and doctors in their reporting of suicide and suicide attempts.

OVERVIEW

Teenage suicide has puzzled experts in the field of suicidology and caused much alarm in communities throughout the country over the past several decades. According to the National Center for Health Statistics, suicides among people ages 15 to 24 increased nearly 300 percent from 1950 to 1980, while suicides among the general population increased by only 11 percent. At the present rate, experts predict that some 5,000 to 7,000 adolescents will commit suicide in 1985, and another 250,000 will attempt suicide. Based on available data, suicide is ranked second as the leading cause of death among teenagers after automobile accidents. Just as alarming are statistics which indicate that 8 to 14 year olds commit suicide at a rate of 100 to 200 per year, making suicide the eighth leading cause of death among this group in the country.

While these statistics are appalling, most authorities believe that the figures would be even higher if more accurate records were kept. In many instances, deaths of a suspicious nature are not labeled as suicide to shield the family or protect insurance benefits. Too, there is no way of knowing how many fatal vehicular accidents are, in fact, intentional suicides. Victor M. Victoroff, M.D., wrote in his book, The Suicidal Patient (1983):

> Suicides that are either not fully intended or are altogether unintended are not considered at all in vital statistics on self-destructive acts. Considering all this, tables that purport to display raw numbers of suicides are underreported. And it's tempting to say they are grossly underreported.[3]

Conceivably, suicides could replace automobile accidents as the leading cause of death among young people if coroners were more realistic in their reporting.

Besides vehicular accidents, other acts or behavior which connote a propensity towards self-destruction leave authorities with cause to wonder. According to Victoroff, any definition of suicide should consider two factors: 1) the degrees of intention and 2) awareness. In essence, to assess the intent of a suicidal act one must look at the level of lethality implicit in the act. For example, a bullet in the head is presumed to be an act of high lethality. Each suicidal act carries with it a degree of lethality which, in many instances, is congruent with the person's intentions. Awareness relates to how conscious the person is that the suicidal act will bring about death.

While, for the most part, the majority of teenagers who commit suicide appear to do so quite deliberately, there is a growing concern regarding a dangerous sexual practice among young males. The practice involves near-asphyxiation by tightening a noose around the neck to heighten self-induced pleasure.[4] The deaths of some teenage males are attributable to this practice.

EFFORTS TO CURB SUICIDE RATE

The high rise in teenage suicides has not gone unnoticed or unchallenged. This bewildering phenomenon has touched many communities across the country and has been the focus of national attention. Parents, teachers, school counselors, psychologists and mental health officials have worked vigorously to establish programs and revitalize services to curtail the tide of suicidal death among young people. Presently, there are some 500 suicide-prevention centers across the country with hotlines staffed by thousands of professionals and volunteers. To complement the efforts of these centers, communities and schools have engendered workshops, courses, counseling programs and published materials to help teenagers, parents, teachers and youth workers understand depression, its symptoms and how it can be overcome.

One example of such a program is Denver's Cherry Creek Suicide Prevention Project which was established in 1980 after four Denver teenagers committed suicide during an 18-month period. The project was initiated by a group of school counselors, psychologists and social workers who were interested in creating public awareness of the problem and providing an immediate support system for those who needed it. This project became the first in-school, federally funded suicide-prevention program in the country. Each Cherry Creek school has a mental health team composed of a psychiatrist, a social worker and a staff of counselors who offer seminars and counseling to students, parents and school personnel. As part of the general health course, students discuss the warning signs of a potential suicide and what to do if a friend emits these symptoms. Too, teachers and counselors are given guidelines for identifying the "high-risk" student.

Efforts comparable to the Cherry Creek project are now visible throughout the country. There is more publicity of mental health facilities and crisis hotlines, and many schools have made suicide-awareness classes a part of the regular curriculum. Also, this current wave of concern and bewilderment has been reflected in the national as well as local media through numerous television programs, radio talk shows and countless magazine and newspaper articles.

Another exemplary program is conducted by the Suicide and Crisis Center in Dallas, Texas. It was founded in 1969 and is accredited by the American Association of Suicidology. Funded solely by donations, this center has expanded its services beyond the original 24-hour hotline to include support groups, outreach teams, public speaking, research and inservice training for other professional agencies. The staff which consists of 100 volunteers and six paid professionals also developed the five-lesson-plan curriculum currently used by the Dallas public schools; for school counselors they offer a six-hour crisis-intervention skills training workshop. When research indicated that teenagers were more likely to turn to a friend when experiencing a problem, the center began to train teenagers as crisis counselors. They report that one third of their calls are from persons under 25 years of age.

In the past several years at least two state legislatures have addressed the problem of teenage suicide. In 1983 a bill was passed by the California Legislature to develop a statewide youth suicide-prevention program through the establishment of state-mandated demonstration programs in two counties. These models will serve as coordinating centers for the planning and development of the statewide initiative. A report of their findings is due January 1, 1987.

In 1984 the Florida Legislature passed the Florida Youth Emotional Development and Suicide Prevention Act to confront the teenage suicide rate and the contributory factors. The act calls for coordination between educational programs and community suicide-prevention and crisis-center agencies. The Department of Health and Rehabilitation Services, through an interprogram task force, was to have developed and submitted a plan for the prevention of youth suicide by January 15, 1985.

On October 27, 1983, the U.S. House of Representatives Select Committee on Children, Youth and Families held a public hearing entitled "Teenagers In Crisis: Issues and Programs." The committee invited youth experts from around the country who gave testimony on the plight of teenagers and innovations in programs and services to help them with their problems. Teenage suicide was a major focus of the three panels who spoke.

Finally, the National Institute of Mental Health (NIMH) has included in its 10 objectives for control of stress and violent behavior a number of goals related to teen suicide:

1. By 1990, the proportion of the population over the age of 15 which can identify an appropriate community agency to assist in coping with a stressful situation should be greater than 50 percent; and

2. By 1990, the proportion of young people ages 15 to 24 who can identify an accessible suicide-prevention "hotline" should be greater than 60 percent.

A recent article by Silver, Goldston and Silver disclosed that the above objectives "primarily involve increasing the public's awareness of community resources, their readiness to use these resources, and their ability to identify the type of assistance - professional or nonprofessional or both - that is needed."[5]

A third goal states that by 1990, the rate of suicide among people ages 15 to 24 should be fewer than 11 per 100,000. Presently, NIMH and Centers for Disease Control (CDC) are looking at a variety of factors associated with teen suicide rates, including race, sex, geographical location and method.

WHAT RESEARCH REVEALS ABOUT TEENAGE SUICIDE

Much research on adolescent suicide is available and contains many diverse theories about its causes. Collectively, the studies tend to raise more questions than they offer answers. According to the authors of one study, "no single theory sufficiently explains the etiology of suicide, and research to date on adolescent suicide has produced only conflicting results."[6]

The problems related to the lack of accurate statistics due to the tendency to underreport probable suicides has been mentioned. Nontheless, even with inaccurate figures the crucial nature of the problem is apparent. Statistics show that:

1. Each year 5,000 young people die from suicide.

2. Deaths of young males account for almost the entire increase in teenage suicide.

3. Five to ten times as many girls attempt suicide as boys, but boys use more lethal methods and succeed four times as often.

4. Many suicide victims are high achievers.

Generally, experts postulate a number of contributory factors to account for the rise in teenage suicide. Those factors include broken homes, suicidal parent or relative, drug and alcohol use, pressures of adolescence, sexual promiscuity, lack of family ties, influence of movies and television and lack of coping skills. Most acknowledge that the adolescent period is beseeched by physical and social changes which require constant adjustment as youth bridge the gap between childhood and adulthood. Csikszentmihalyi and Larson write in their book Being Adolescent (1984) that:

> "Regardless of the society, physiological changes at puberty transform the former child into a youth armed with new powers of strength and sexuality. These upheavals, both social and physical, can never be entirely smooth. Every culture must find ways to prevent them from disrupting its continuity. In effect, every culture must find ways of engaging its youth in the responsibilities of being adults."[7]

In the opinion of many youth specialists, today's youth must deal with the natural physical, mental and emotional changes, as well as the additional pressures of society. These pressures come in the form of greater social freedom with few limitations and many choices. Teenagers are exposed to drugs, alcohol and sex at a much younger age than ever before, and many have not developed the ability to cope with these social changes. Many youth succumb to peer pressure to experiment in these areas, perhaps with devastating results.

Another pressure often spoken of in the literature is the burden placed on young people to succeed academically and enter a promising career. Some writers feel that students are "overprogrammed" by accelerated courses and activities such as music lessons, team sports and social clubs so that they can get into one of the "better" colleges. Not only are youth encouraged to get good grades but they must also compete in extra-curricular activities and do well on the Scholastic Aptitude Test. George Cohen, chairman of the Suicide Task Force in Westchester County, New York, was quoted in a recent article: "We've sold kids on the idea that the road to happiness is going to Harvard. But not everyone can get in, and these kids don't realize that it's a big world out there. We've got too many fourteen year olds who are already cynical and depressed about the future."[8]

Coupled with the competition to do well academically and overcome the stress and tension of social life, teenagers must also contend with disarray in their families' lives. Roughly half of all first marriages end in divorce. Too, there are added pressures when both parents work. Ronald Maris, editor of Suicide and Life-Threatening Behavior, contends that "young people are experiencing serious threats to the two things that Freud said were most important to mental health - love and work. For some, that leads to what I consider the root of all suicides: A sense of hopelessness, a feeling that things will not get better."[9]

According to one writer, "families have lost the ability to teach coping skills, to teach calmness, to teach preseverance."[10] Modern society is addicted to instant gratification and quick cures. Drinking, drugs and violence are portrayed as acceptable methods of dealing with problems and seem to provide an easy way out of responsibility. The breakdown in family structure, which is sometimes due to outside pressures, makes it impossible for parents to serve as positive models for emotional growth. As a consequence, a generation of youth less able to deal with the pressures of life search for relief through self-destructive behavior.

There is a general consensus among experts that the underlying cause of most suicidal behavior is depression. Because of the lack of coping skills, many young persons are unable to handle periods of depression and appear unable to perceive that the situation will get better. Kurt Glasser, a noted psychiatrist who has written prolifically on masked depression in young people, contends that: "Young people feel loss acutely. Loss of almost anything - not just loss of a parent, but loss of success in school, loss of self-esteem or self-respect, loss of friends and teachers and a familiar neighborhood, even the loss of childhood."[11] When the sense of loss becomes so overwhelming or is complicated by yet another loss, serious depression can set in.

Researchers have found that two types of behavior are often present when a teenager is in the midst of a serious depression. One form of behavior is characterized by withdrawal. As stated by Aurora Mackey, "They withdraw into themselves and progressively cut themselves off from the world, so that, in a way their depression becomes invisible to others. These are the teens who are at the highest risk of succeeding in suicide attempts."[12] This is especially true in families where anger and grief are not viewed as a natural human response. According to Herbert Hendin,

author of Suicide in America (1982), many depressed teenagers employing this method may use academic life as a defense. He wrote that "these students used the continued deployment of uninteresting and methodical work in the service of a withdrawal from either satisfaction or rage."[13]

A second method of dealing with serious depression is through "acting out." Unconsciously, the teenager tries to get rid of his/her feelings by acting them out rather than dealing with the situation head on. Such behavior may take on various forms such as risk-taking, running away, drug or alcohol abuse or sexual promiscuity. Typically, adults view many of these behaviors as delinquency when, in fact, such behavior may mask serious depression. Says Glasser, "adolescents are action-oriented: They reveal their feelings in actions rather than in words. So a sudden change in behavior in an adolescent is often a warning signal."[14] He notes that punishment merely treats the symptoms but not necessarily the underlying problem. He concludes: "We need to remember that the disturbing behavior is not the problem, but only a symptom of the problem. If we don't help this student provide some relief from the problem and pain - he'll find his own relief, perhaps in drugs."[15]

Literature on teenage suicide also mentions the adolescent who may use the threat of suicide to control and manipulate others. In many instances, such a youth will slash wrists or take an overdose of pills with the expectation of being rescued. Obviously, such threats should always be taken seriously; nonetheless, there is an imminent danger that the youth will miscalculate the arrival of a parent or dosage of drugs which may be fatal. The manipulative adolescent is a dilemma for parents, as well as psychiatric professionals.

Recent studies on adolescent suicide may provide some clues to understanding self-destructive behavior and its contributory factors. Tishler, McKenry and Morgan (1981) examined 108 adolescents who attempted suicide during a two-year period. They assessed family background, mental status and events which precipitated the suicidal attempt. Fifty percent of the adolescents reported that at least one of their parents had been divorced. Sixty percent rated their parents' marriage as poor. These findings are congruent with the findings of other studies which revealed that marital instability, marital unhappiness, disruption of residence and inadequate parental functioning are prevalent factors in the families of suicidal youth.

The mental status examination administered to the 108 subjects also indicated vegetative symptoms of depression (sleep disturbances, appetite disturbances, vague somatic complaints). The study found that 81 percent evidenced sleep disturbance; 62 percent witnessed a noticeable change in weight; and 86.5 percent experienced inappropriate affect, or behavior that is incongruent with the situation, such as uncontrollable crying or sadness.

Finally, an assessment of the events precipitating the suicidal attempt revealed that the most frequently cited reason for the attempt was parental problems. This reason was followed by problems with the opposite sex and school problems, respectively. The authors readily noted that "an

unstable family environment could easily lead to problems with peers, school, and members of the opposite sex."[16]

Tishler, McKenry and Morgan concluded that "the decision of the adolescent to attempt suicide appears to be the combination of long-standing problems as well as the impact of a recent precipitating event. Vegetative signs of depression were noted to some degree in nearly all patients."[17] They noted that many of their subjects had unstable family backgrounds which impaired coping skills. As a result, the normal adolescent developmental adjustment problems escalated into unmanageable stress situations.[18] Accordingly, these findings support the theory that adolescent suicide is the result of a progression of problems through three stages: 1) a long-standing history of problems; 2) a period of escalation and intensification of problems by an introduction of new problems associated with adolescence; and 3) a final state - a recent onslaught of problems usually characterized by a change in or desolution of any meaningful social relationship.[19]

Another study of note was conducted by Topol and Reznikoff (1982) who compared 30 hospitalized suicidal adolescents with 34 hospitalized nonsuicidal teenagers and 35 nonhospitalized coping youngsters regarding their problems, perceptions of peer and family relationships, degree of hopelessness and locus of control. They found that: 1) the suicidal adolescents felt that they had more total problems, serious problems and serious family problems than the other two groups; 2) 11 of the 30 suicidal patients discussed their problems with no one and five shared their difficulties primarily with their therapists, while 32 of 35 in the control group had a family member or peer to confide in (suicidal females were less likely than their male counterparts to have a close confidant); 3) of the three groups, suicidal teens perceived their families as the least well-adjusted; and 4) suicidals to a greater degree felt a sense of hopelessness about the future and a lack of control over their environment.

Finally, Ronald Maris, who has done extensive research on suicide, contends that many persons who commit suicide or attempt it have had a suicide role model in their own families. Too, he feels that a decline in religious values among the young make them less resilient in facing life's difficulties.

MYTHS REGARDING TEENAGE SUICIDE

There are many myths associated with suicide, especially suicidal children and youth. One common myth is that many suicides or attempted suicides are impulsive acts brought on by trivial incidents, for example, a breakup with a boyfriend or girlfriend, an argument with a close friend or dispute with a parent. This is a misconception. Interviews with suicide-attempt victims indicate that the self-destructive act is caused by a buildup over time. Many had tried to deal with their problems in various ways but progressively felt that no one understood.

Another misconception is that suicides occur only among the rich or well-to-do in American society. Statistics show that suicide is proportionately represented in all socio-economic/racial groups. While much of the alarm has been triggered in affluent suburbs, the incidence of suicide is increasing everywhere. Regarding sex and race, the greatest increase has been among males of both races in the 15 to 24 age group. There is a modest increase among white females and almost no increase in the suicide rate of black females. A 1978 study on black suicide indicated that blacks between the ages of 15 and 24 commit suicide at a higher rate than the total population of blacks in all age groups.[20]

One myth surrounding adolescent suicide is that talking about it will give teenagers ideas and may cause a rippling effect. Experts contend that just the opposite is true. They theorize that talking about the subject is the first step toward prevention since it allows many troubled adolescents to discuss their fears and realize that there are options which they had not imagined. Francine Klagsbrun in her book Too Young To Die wrote, "you don't give a suicidal person morbid ideas by speaking about suicide. The person has the ideas. You can help by bringing suicidal thoughts into the open so they can be talked about."[21]

While one outward sign which indicates a teenager's risk to suicide is a broken or troubled home, statistics indicate that suicide frequently occurs in intact homes where deep-seated problems are difficult to detect.

Various other myths contend that suicide occurs without warning, youth who talk about suicide rarely carry it out and those who commit suicide are mentally ill. These are all misconceptions which may cause one to overlook a potential suicide victim who is in need of help. A general rule is to take all verbalizations or insinuations regarding suicide seriously.

WARNING SIGNS

Mental health professionals have compiled a list of warning signs which often point to serious depression that could lead to suicide:

1. A suicide threat or any comment regarding a desire to die (75 percent of persons who successfully commit suicide had told someone they were thinking of doing it.)

2. A dramatic change in personality, such as a shy person suddenly becoming outgoing or an extroverted person becoming silent and withdrawn

3. Previous suicide attempts

4. Sleep disturbances

5. A change in eating patterns, often marked by a sudden loss or gain of weight

6. A dramatic drop in school performance

7. Themes of suicide, death or depression in essays or artwork

8. Withdrawal from family, friends or any prior interest (including hobbies)

9. The use of drugs or alcohol, which only temporarily masks true feelings

10. Giving away prized possessions or making final arrangements such as writing a will

Experts recommend a number of steps to be taken if a young person gives off warning signs which appear to be suicidal. They strongly state that the worst thing any parent, teacher or friend of a suicidal person can do is nothing. It is important to remember that the young person who wants to die also desperately wants to live. Following is a list of pointers which are recommended to prevent a suicide:

1. If you have questions about a teenager's intentions, verbalize your fears and communicate your concern for his/her well-being.

2. Listen to his/her concerns and show support. Do not act horrified by what he/she tells you.

3. Talk openly and ask direct questions. Don't be afraid to ask if he or she has a suicide plan (how, when, where). The more detailed the plan, the more serious the threat.

4. Take everything he or she says dead serious. Never tease, challenge or try to shock him/her out of the decision to carry out the threat.

5. Seek professional help.

6. Remove any guns, potentially lethal medication, alcohol, etc. from the home.

7. Don't let the teenager convince you that the crisis is over. The most dangerous time prior to a suicide attempt is when the youth appears to be getting better.

8. Don't leave him or her alone if you believe the risk of suicide is imminent.

It is not important that a parent or teenager be able to explain why life is worth living. Suicidal adolescents just want to know that someone cares. Teachers are encouraged to be caring laypersons rather than attempt to be psychiatric professionals.

STATISTICS ON TEENAGE SUICIDE

According to the Division of Vital Statistics, National Center for Health Statistics, 5,161 young people between the ages of 15 and 24 committed suicide in 1981. Of that number, 1,772 were between the ages of 15 and 19 (see Table I). A further breakdown of the data shows that the vast majority (3,775) were white males. The present trend, around 12.3 per 100,000 for the 15 to 24 age group, has led authorities to estimate that one-half million teenagers make attempts on their lives each year. Some believe that a million children and youth each year manifest suicidal thoughts. Looking at these figures, it is not surprising that suicide is now the second leading cause of death among the 15 to 19 year olds after traffic accidents.

In Table I are statistics compiled by the Division of Vital Statistics which show the numbers of suicidal deaths recorded in the United States for the 11-year period, 1970 - 1981, among the 15 to 24 age group.

TABLE I

Death Due to Suicide in the United States (ages 15 to 24)

YEAR	TOTAL ALL GROUPS	WHITE MALES	WHITE FEMALES	BLACK MALES	BLACK FEMALES
1981	5,161	3,775	856	316	71
1980	5.239	3,881	811	346	69
1979	5,246	3,727	875	389	97
1978	5,115	3,689	869	356	76
1977	5,565	4,027	948	349	105
1976	4,747	3,354	839	341	101
1975	4,736	3,378	832	323	86
1974	4,285	3,025	796	274	88
1973	4,098	2,905	706	302	83
1972	3,858	2,540	738	338	114
1971	3,479	2,326	735	214	113
1970	3,128	2,116	649	214	84

Source: Division of Vital Statistics, National Center for Health Statistics

The figures show that from 1970 to 1977 there was a continuous rise in the suicide rate for all groups, corresponding mainly with the tremendous rise in suicidal deaths among white males. Since 1977 the total number of suicides has remained above 5,000.

Table II shows a breakdown of 1980 suicide statistics for the 10 to 24 age group by state. North Carolina had three suicides in the 10 to 14 age group, 46 in the 15 to 19 age group and 83 in the 20 to 24 age group for a total of 132, ranking the state tenth in the number of suicidal deaths among young people. Worthy of special note is the sharp increase among the 20 to 24 age category over the 15 to 19 age groups in all states, in many instances by 50 to 100 percent. This may be due to the high suicide rate among college students, significantly higher than for youth not in college. According to Hendin, "the assumption has prevailed that academic pressures reflecting familiar and cultural demands for achievement are primarily responsible."[22]

TABLE II

NATIONWIDE SUICIDE STATISTICS (ages 10-24)

from the
National Center for Health Statistics (1980)

North Carolina has the 10th highest suicide rate
(including the District of Columbia)

STATE	10-14 AGE RANGE	15-19 AGE RANGE	20-24 AGE RANGE
Alabama	6	19	55
Alaska	1	6	15
Arizona	4	33	62
Arkansas	1	22	23
California	15	191	357
Colorado	5	30	60
Connecticut		18	32
Delaware		6	10
District of Columbia		4	7
Florida	8	81	177
Georgia	5	42	79
Hawaii		4	19
Idaho	1	9	18
Illinois	6	84	156
Indiana	1	38	57
Iowa	4	17	36
Kansas	1	19	46
Kentucky	3	32	50
Louisana	6	47	73
Maine	2	10	16
Maryland	1	27	64
Massachusetts	1	31	73

STATE	10-14 AGE RANGE	15-19 AGE RANGE	20-24 AGE RANGE
Michigan	7	76	140
Minnesota	3	33	69
Mississippi		15	40
Missouri	7	43	71
Montana		12	16
Nebraska	1	10	18
Nevada*		11	28
New Hampshire	1	6	14
New Jersey	2	42	83
New Mexico	2	15	49
New York	10	103	196
North Carolina*	3	46	83
North Dakota		10	16
Ohio*	5	91	162
Oklahoma		2	27
Oregon	2	31	45
Pennsylvania	6	90	175
Rhode Island		6	16
South Carolina		22	35
South Dakota	2	9	11
Tennessee	1	27	58
Texas	10	136	246
Utah		11	30
Vermont	1	7	10
Virginia		44	88
Washington		33	87
West Virginia	1	14	30
Wisconsin	1	53	75
Wyoming	1	4	15
TOTALS	137	1,772	3,418

TOTAL, AGES 10-24 5,327

* State has suicide deaths for 5-9 age range

Displayed on Table III are data on suicides committed in North Carolina from 1970-1983 by age group. The year 1982 witnessed the highest rate of suicides among all groups with a total of 800. Coincidentally, the 15 to 19 age group experienced its highest total (60) during this same period. In 1983 suicides among the 15 to 19 age group were the lowest (30) in 13 years.

TABLE III

SUICIDES IN NORTH CAROLINA 1970-1983

YEAR	TOTAL ALL AGES	AGES 10-14	AGES 15-19	AGES 20-24
1983	748	6	30	87
1982	800	2	60	85
1981	766	6	48	78
1980	657	3	46	84
1979	703	3	49	67
1978	656	3	38	61
1977	732	3	47	86
1976	681	4	44	68
1975	738	7	49	71
1974	690	7	31	69
1973	702	7	42	53
1972	639	3	33	53
1971	606	5	22	47
1970	540	1	25	28

Source: State Center for Health Statistics

Table IV contains data on suicides committed in North Carolina between 1970 and 1983 by race and sex among 15 to 24 year olds. As evident in the national data, the white male is the group most at risk in the state while the non-white female is the least. The National Institute of Mental Health is suggesting that more studies be done on the psychosocial factors that differentiate white males from other groups.

TABLE IV

SUICIDES IN NORTH CAROLINA BY RACE AND SEX 1970-1983

YEAR	TOTAL ALL AGE GROUPS	WHITE MALES 15-24	WHITE FEMALES 15-24	NON-WHITE MALES 15-24	NON-WHITE FEMALES 15-24
1983	748	78	21	15	3
1982	800	96	27	20	2
1981	766	88	20	12	6
1980	657	98	20	11	1
1979	703	75	23	14	4
1978	656	65	14	16	4
1977	732	87	22	21	3
1976	681	71	19	16	6
1975	738	77	24	15	4
1974	690	64	19	13	4
1973	702	65	11	14	5
1972	639	47	18	14	7
1971	606	42	18	9	0
1970	540	36	10	5	2

Source: State Center For Health Statistics

The preceding data are appalling yet quite aptly illustrate the critical nature of the teenage suicide problem in North Carolina and the nation. This tragedy is further illuminated when one considers that countless suicides are reported as accidental injury. If the present trend is continued, some 100 to 150 young people between the ages of 10 and 24 will commit suicide this year in North Carolina.

SURVEY OF SUICIDE PREVENTION/INTERVENTION SERVICES IN NORTH CAROLINA

Procedure

In the summer of 1984 the Governor's Advocacy Council on Children and Youth embarked on a study to ascertain the availability of services for suicidal youth in North Carolina. A master list of agencies across the state which offer suicide and self-harm prevention, crisis intervention and personal counseling was obtained from the Information and Referral Office/Careline of the Department of Human Resources. There was a total of 41 suicide and self-harm prevention services, 210 crisis-intervention programs and 794 services offering personal counseling. Many agencies were listed in all three categories. From this master list a total of 150 services and programs were selected to be surveyed, including all of the suicide and self-harm prevention services and some of the crisis-intervention and personal counseling services which indicated a propensity towards youth.

A questionnaire containing 16 items was prepared to solicit the responses of the 150 services and programs identified as suicide intervention/prevention facilities. The instrument was designed to elicit the following information:

1. Availability and extent of services
2. Staffing patterns
3. Sources of funding
4. Percentage of clientele in the 13 to 24-year-old category

All questions were of the checklist or open-ended variety. A copy of the survey form is included in Appendix A.

Of the 150 questionnaires mailed out, 10 were returned as non-deliverable at the addresses available on the master list. Thirty-nine were returned incomplete or with notes attached indicating that their services did not provide suicide intervention or prevention. Only 86 of the returned questionnaires were considered complete enough to be analyzed.

Results

One concern of the council related to sources of funding available to suicide-prevention services and whether funds for services had increased or decreased during the last five years. Over two-thirds of the respondents indicated that they had two or more funding sources. Seventy-five percent responded that funds were received from county and local governments while approximately 60 percent received state funds and 45 percent received federal funds. Church groups provided funding for 25 facilities and 20 respondents received funds from charitable organizations or individuals. United Way and private donors were most often specified in the latter category. Only 12 percent of the respondents indicated private grants as a source of funds.

In response to question number 4 regarding the services budget and whether it had increased or decreased over the past five years, 65 percent answered that there had been an increase. Around 25 percent indicated that there had been a decrease in funds and the remainder responded that there had been no charge.

Question number 5 asked respondents what percentage of their services related to suicide prevention/intervention. Only 70 of the 86 respondents answered this question. Of those, 38 indicated five percent or less and 32 replied that this component involved from 10 to 50 percent of their services. Only one facility, the Crisis Control Center in Greensboro, dedicated 100 percent of its services to suicide prevention/intervention.

Most of the respondents had 24-hour services. Only 11 operated on a five-day week, generally 8 a.m. to 5 p.m. or 9 a.m. to 6 p.m. One of these, the Child Guidance Clinic of Winston-Salem, operated for one-half day on Saturdays. Four respondents did not answer this question.

Beyond the 24-hour service that was available at most of the facilities, other services such as hotlines, referral systems, crisis housing, medical care and special programs for adolescents varied a great deal among participants in the survey. Fifty-two (60 percent) of the respondents indicated that they had hotline services available. Some who did not have this service commented that they could be contacted through law enforcement and other emergency assistance personnel.

A walk-in service was offered by 57 facilities (66 percent), and 75 (81 percent) responded that they could offer immediate action in a crisis situation. All but 11 had a mechanism for referrals.

One service that was sparsely available among the participant facilities was crisis housing. Only 30 percent of those surveyed answered in the affirmative to this question. There were also wide variations in the amount of health care available. One-third of the facilities offered services of a medical doctor or nurse and mental health care while another third offered only the latter. The remainder offered no health care at all.

Of special significance to teenagers is the availability of special programs to address their needs. Forty-three percent (37) of the respondents indicated that they had such programs.

Responses to questions regarding staff indicated that the numbers and degree of training required of personnel were dictated by the type of facility and its overall purpose. Suicide prevention/intervention programs offer different levels of services with varying responsibilities, ranging from large hospitals with a cadre of psychiatrists to crisis centers supported mainly by volunteers. Note Table V. Overall, most facilities require professional personnel to have a minimum of a bachelor's degree (many require a master's) and volunteers to undergo a training program before administering services to clients.

The question related to the percentage of clientele in three age categories between 13 and 24 also drew a wide variation in responses. As with staffing, the percentage of youth served was dictated by the size, purpose and

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED								No Prof.	No Vol.	Trng. Prof.	Trng. Vol.	% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer.	Immed. Action	Crisis Housing	Health Care	Follow Up	Spec. Programs						13-15	15-19	19-24	
Baptist Childrens Home, Inc. P. O. Box 338 Thomasville, NC 27360 (919) 476-4472	All Counties	5 Days	No	Yes	Yes	No	Yes	No	No	Yes	26	0	BSW	N/A	5	15	50	0	1
Bragtown Project 320 Belvin Avenue Durham, NC 27704 (919) 471-1554	Durham	_*	No	No	Yes	No	No	No	No	No	3	0	M. Ed.	N/A	-	5	-	-	-
Brynn Marr Neuropsychiatric Hospital 192 Village Drive Jacksonville, NC 28540 (919) 577-1400		24 hrs.	Yes	Yes	No	Yes	No	Yes M. D. Nurse	Yes	Yes	72	0	Prof. level	N/A	20	40	30	30	5-10
Child Guidance Clinic 1200 Glade Street Winston-Salem, NC 27101 (919) 723-3571	Davie, Davidson, Forsyth, Guilford, Iredell, Rowan, Stokes, Surry, Yadkin, & Wilkes+ **	5 Days, ½ Saturday	Yes	Yes	Yes	Yes	No	Yes	Yes	No	10	0	M. A.	N/A	5	6	4	5	10
Children & Youth Services, Blue Ridge Center 356 Biltmore Avenue Asheville, NC 28801 (704) 258-2597	Buncombe, Yancey, Madison, Mitchell	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M. D. Nurse	Yes	Yes	7	0	M	N/A	20	30	30	-	10
Christian Counseling Center 1064 S. Church Street Burlington, NC 27215 (919) 227-5476	Alamance+	-	No	No	No	No	No	Yes	No	No	3	0	N. A.	N/A	1-5	13	13	18	<1 less than one
Community Guidance Clinic 402 Trent Street Durham, NC 27705 (919) 286-4456	Durham	24 Hrs.	No	Yes	Yes	Yes	No	Yes M. D. Nurse	Yes	Yes	20	0	Prof.	N/A	10	30	30	0	25
Contact of Fayetteville, Inc. P. O. BOX 456 Fayetteville, NC 28302 (919) 484-4134	Cumberland+	24 Hrs.	Yes	No	Yes	Yes	No	No	No	No	93	92	N/A	72 Hrs.	-	2.2	2.2	-	3

*- indicates no response to the question.
**+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED												% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer.	Immed Action	Crisis Housing	Health Care	Follow Up	Spec. Programs	No Prof.	No Vol	Trng Prof.	Trng. Vol.		13-15	15-19	19-24	
Contact - High Point 463 South Main Street High Point, NC 27260 (919) 885-0191	Guilford Randolph Davidson	24 Hrs.	Yes	No	No	Yes	No	No	No	No	No	100	-	-	-	-	-	-	-
Contact Davidson County P. O. Box 924 Lexington, NC 27293 (704) 249-8824	Davidson	24 Hrs.	Yes	No	Yes	Yes	No	No	No	No	90	89	-	50 Hrs.	-	3.3	3.3	3.3	26
Contact Teleministry of Johnston County 140 Market Street Smithfield, NC 27577 (919) 934-6979 934-6161 (Hotline)	Johnston	24 Hrs.	Yes	No	Yes	No	No	No	No	No	8	130	-	50 Hrs.	10	-	-	-	5
Contact-Telephone Counseling 501 N. Tryon Street Charlotte, NC 28202 (704) 372-1580	Mecklenburg, Union+	24 Hrs.	Yes	No	Yes	Yes	No	No	No	Yes	1	300	B. A.	80 Hrs.	15	-	-	-	65
Contact -Durham Telephone Crisis Ministry 809 Chapel Hill Street Durham, NC 27707 (919) 683-1568	Durham	24 Hrs.	Yes	No	Yes	No	No	No	No	No	76	75	-	50	<1 less than one	8	8	8	3-5
Wilson Crisis Center P. O. Box 593 Wilson, NC 27893 (919) 237-5156	Wilson	24 Hrs.	No	No	Yes	Yes	Yes	No	No	No	-	-	-	2	-	-	-	-	2
Crisis Control Center P. O. Box 80663 Greensboro, NC 27419 (919)852-4444	Guilford	24 Hrs.	Yes	No	Yes	No	No	No	Yes	No	1	79	High School	24	100	-	-	-	-
Anson County Crisis Council 209 E. Wade Street Wadesboro, NC 28170 (704) 694-2834	Anson	24 Hrs.	Yes	No	Yes	Yes	No	No	Yes	Yes	2	2	College	77	33	10	20	25	2

*- indicates no response to the question.
**+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED												% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer	Immed Action	Crisis Housing	Health Care	Follow Up	Spec Programs	No Prof.	No Vol.	Trng Prof.	Trng Vol		13-15	15-19	19-24	
Crisis Line/Open House 419 Chestnut Street Wilmington, NC 28401 (919) 763-3695	Pender, Brunswick New Hanover (Watts line all counties)	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M. D. Nurse	Yes	Yes	6	15	B. A.	40 Hrs.	5	30	30	20	7-15
Dial Help of Rowan County Inc. P. O. Box 4026 Salisbury, NC 28144 (704) 636-9222	Rowan	24 Hrs.	Yes	No	Yes	Yes	No	No	No	No	120	120	-	25	<1 less than one	.5	.5	-	3
Division of Child and Adolescent Psychiatry Box 2906 Duke University Medical Center Durham, NC 27706 (919) 684-3044	Durham+	24 Hrs.	No	Yes	No	Yes	Yes	Yes M. D. Nurse	Yes	Yes	-	-	-	-	5	10	35	55	10
Division Social Work Officer HSC, 307th Med Bn. Ft. Bragg, NC 28307 (919) 396-8903	82D Airborne Division		No	No	Yes	Yes	No	Yes	No	No	-	-	-	-	1	-	-	-	.5
Emergency Shelter (Of Youth Opportunity Homes, Inc.) 1204 Brockstown Avenue Winston-Salem, NC 27101 919) 748-0003	All	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M. D. Nurse	Yes	No	8	0	B. A.	N/A	-	ALL BETWEEN 10-17		0	42
Family Life Center P. O. 586 Lexington, NC 27292 (704) 249-9829	Davidson	8 Hrs. 5 Days	No	No	Yes	No	No	No	No	No	1	0	Master	N/A	5	5	10	20	3
Helpline 333 McMasters Street Chapel Hill, NC 27514 (919) 929-0479	Orange, Chatham, Person	24 Hrs.	Yes	No	Yes	No	Yes	Yes	Yes	No	90	90 (1.5 Paid	B. A.	49	5	1	5	15	20
Helpline of Durham (Mental Health Center) Durham, NC 27701 (919) 683-2392	Durham+	24 Hrs.	Yes	No	Yes	Yes	No	Yes	Yes	No	45	30	-	43	2	-	-	-	5-10

*- indicates no response to the question.
**+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED													% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer	Immed. Action	Crisis Housing	Health Care	Follow Up	Spec. Programs	No. Prof.	No. Vol.	Trng. Prof.	Trng. Vol.			13-15	15-19	19-24	
Helpline (24 Hours) Army Community Service - DPCA Ft. Bragg, NC 28307-5000 (919) 396-HELP (4357)	All	24 Hrs.	No	No	Yes	Yes	No	No	Yes	No	2	0	B. A.	N/A	1	-	-	-	1
Helpline Box 3537 Morehead City, NC 28557 (919) 247-3023	Carteret	24 Hrs.	Yes	No	No	No	Yes	No	Yes	No	30	30	-	36	10	1	4	3	2
Roanoke-Chowan Human Services Center Wiccacon Center P. O. Box 407 Harrellsville, NC 27942 (919) 356-2938	Bertie, Gates, Hertford, Northampton	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes	No	No	5	0	B. A.	20	-	2	3	10	-
Industrial Counseling Service, Inc. 1200 Arlington Street Greensboro, NC 27406 (919) 273-1566	Guilford Rockingham	8:30am. 6:00pm. M - F	No	No	Yes	Yes	No	Yes	Yes	No	4	0	M. A.	N/A	1	5	5	20	1
Juvenile Probation Services P. O. BOX 370 Windsor, NC 27983 (919) 794-3377	Hertford Bertie	24 Hrs.	No	Yes	Yes	Yes	No	No	No	No	5	0	B. A.	N/A	-	95	5	0	0
Juvenile Services Center (DYS) 2089 Draughone Street Fayetteville, NC 28302 (919) 485-8193	Cumberland, Hoke, Moore, Montgmery, Harnett, Anson, Robeson Sampson, Bladen, Duplin Richmond +	24 Hrs.	No	No	No	Yes	Yes	Yes M. D. Nurse	No	Yes	12	0	H. S.	N/A	25	90	10	0	1
Lincoln Community Health Center 1301 Fayetteville Street Durham, NC 27707 (919) 683-1316	Durham+	5 Days 9:00am-5:00pm Tues. 9:00am-8:00pm	No	Yes	Yes	No	No	Yes M.D. Nurse	Yes	Yes	7	0	B. A.	N/A	10	10	20	10	3-5
Mandala Center's Adolescent Treatment Program 3637 Old Vineyard Road Winston-Salem, NC 27104 (919) 768-7710	All	24 Hrs.	No	Yes	Yes	Yes	Yes	Yes M.D. Nurse	Yes	Yes	20	0	N.A. Therap. Workers 2 years College	-	20	60	40	-	25

*- indicates no response to the question.
**+ indicates surrounding area.

TABLE V
SUICIDE PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED												% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer	Immed. Action	Crisis Housing	Health Care	Follow Up	Spec. Programs	No. Prof	No. Vol	Trng Prof	Trng Vol		13-15	15-19	19-24	
Mental Health Center (Bladen County) P.O. Box 1176 Elizabethtown, NC 28337 (919) 862-4908	Bladen	24 Hrs.	No	Yes	Yes	Yes	No	Yes M.D. Nurse	Yes	Yes	6	0	B.A.	N/A	1	15	15	15	1
Mental Health (Gaston-Lincoln) Helpline 401 N. Highland St. Gastonia, NC 28052 (704) 735-4351/867-4357	Gaston Lincoln	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	No	4	0	B.A.	N/A	25	-	-	-	200
Mental Health Center (Guilford County) 300 Edgeworth St. Greensboro, NC 27401 (919) 373-3630	Guilford	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	No	No	13	0	B.A.	N/A	25	2	6	12	60
Mental Health (Wayne County) 301 N. Herman St. Goldsboro, NC 27530 (919) 736-7330	Wayne	24 Hrs.	Yes	No	Yes	Yes	No	Yes	No	No	10	45	B.A.	OJT	1	-	-	-	3
Mental Health (Neuse Center) 1707 Arendell St. Morehead City, NC 28557 (919) 726-0515	Carteret	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	No	No	9	0	M.A.	N/A	5	3	5	5	10
Mental Health Center (Neuse Center) P.O. Box 1005 Havelock, NC 28560 (919) 447-8171	Craven Carteret Jones Pamilico	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M.D. Nurse	Yes	Yes	3	0	M.A.	N/A	10	10	10	20	3
Mental Health Center (Catawba) Route 3, Box 339 Hickory, NC 28601 (704) 328-5361	Catawba	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M.D. Nurse	Yes	Yes	15	0	B.A.	N/A	2	5	7	12	6
Guilford County Mental Health 400 E. Commerce Ave. High Point, NC 27260 (919) 883-1341	Guilford	24 Hrs.	No	No	No	Yes	No	Yes M.D. Nurse	Yes	Yes	4	0	M.A.	N/A	5	40	25	5	1

*- indicates no response to the question.
**+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED								No Prof	No Vol	Trng Prof	Trng Vol	% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer	Immed Action	Crisis Housing	Health Care	Follow Up	Spec Programs						13-15	15-19	19-2*	
Mental Health Center Piedmont Area (Stanly Center) Albemarle, NC 28001 (704) 983-2117	Stanly	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M.D. Nurse	Yes	Yes	11	0	B.A. Lisc.	N/A	25	-	-	-	15
Mental Health (The Union Center) 1310 McCray Street Monroe, NC 28110 (704) 289-5431	Union	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M.D. Nurse	Yes	Yes	14	0	M.A.	N/A	-	-	-	-	8
MH/MR/SAS Blue Ridge Center 123 School Road Bakersville, NC 28705 (919) 688-2210	Mitchell	24 Hrs.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	2.5	0	M.A.	N/A	-	40	<10	<10	2.5
Mental Health Center (New River) Rt. 5, Box 20 A Boone, NC 28607 (704) 264-8759	Watauga, Ashe Avery, Alleghany, Wilkes	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	No	30	0	B. A.	N/A	2	5	8	10	10
Mental Health (Trend Community Services) Community Services Bldg. Brevard, NC 28712 (704) 884-2027	Transylvania	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	No	No	5	25	M. A.	10	5	<1	2	10	5
Mental Health (Mecklenburg) 501 Billingsley Road Charlotte, NC 28211 (704) 375-3575	Mecklenburg	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	26	0	B. A.	N/A	10	19 percent			5
Mental Health (Piedmont Area) 457 Lake Concord Road Concord, NC 28025 (904) 788-4422	Cabarrus Stanly Union	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	No	13	0	M.A.	N/A	10	-	-	-	20.40
Mental Health (Durham County) 414 E. Main Street Durham, NC 27701 (919) 682-9295	Durham	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M. D. Nurse	Yes	No	20	40	M.A.	42	10	0	0	All	

*- indicates no response to the question.
***+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED												% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer.	Immed Action	Crisis Housing	Health Care	Follow Up	Spec. Programs	No. Prof.	No. Vol.	Trng. Prof.	Trng. Vol.		13-15	15-19	19-24	
Mental Health (Onslow County) 215 Memorial Drive Jacksonville, NC 28540 (919) 363-5118	Onslow	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes M.D. Nurse	Yes	No	8	0	B.A.	N/A	5	-	-	-	2
Mental Health (New River) P. O. Box 216 Jefferson, NC 28640 (919) 246-4542	Ashe	24 Hrs.	No	Yes	Yes	Yes	No	Yes	Yes	Yes	8	0	A.B. 24 Hrs. Train.	N/A	50	5	5	10	-
Mental Health Center (Scotland County) 1224 Biggs Street Laurinburg, NC 28352 (919) 276-7360	Scotland	24 Hrs.	No	Yes	Yes	Yes	No	Yes	Yes	No	8	0	B.A.	N/A	1	8	7	10	5
Mental Health (McDowell County) P. O. Box 699 Marion, NC 28752 (919) 652-5444	McDowell	24 Hrs.	Yes	Yes	Yes	No	No	Yes M.D. Nurse	Yes	No	3.5	0	M.A.	N/A	-	30	40	30	5
Mental Health Center (Burke County) 700 E. Parker Road Morganton, NC 28655 (704) 433-4200	Burke	24 Hrs.	No	Yes	Yes	Yes	No	No	No	No	6	0	M.A.	N/A	10	-	-	-	2
Mental Health (Moore Unit) P. O. Drawer 639 Pinehurst, NC 28374 (919) 295-6853	Moore, Hoke, Montgomery, Richmond, Anson	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	No	8	0	B.A.	N/A	-	1	3	5	9
Mental Health (Pitt County) 306 Stantonburg Road Greenville, NC 27834 (919) 752-7151	Pitt	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M.D. Nurse	Yes	No	-	0	B.A.	N/A	-	-	-	-	-
Mental Health (Chatham County) School Based Mental Health Program Rt. 5, Box 5 Pittsboro, NC 27312 (919) 542-4422	Chatham	5 Days	No	Yes	Yes	Yes	No	Yes	Yes	Yes	1 2- P.T.	0	B.A.+	N/A	-	100	-	-	<1

*- indicates no response to the question.
**+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED												% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer.	Immed. Action	Crisis Housing	Health Care	Follow Up	Spec. Programs	No. Prof.	No. Vol.	Trng Prof.	Trng Vol.		13-15	15-19	19-24	
Mental Health (Alleghany) P. O. Box 159 Sparta, NC 28675 (919) 372-4095	Alleghany	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes M.D. Nurse	Yes	Yes	4	0	-	N/A	30	5	10	15	10
Sandhills Center for Mental Health 132 W. Elwood Avenue Raeford, NC 28376 (919) 875-8156	Hoke	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes M.D. Nurse	Yes	Yes	3	0	B.A.	N/A	10-15	10	10	10	10
Mental Health (Roanoke-Chowan) Rt.3, Box 22A Windsor, NC 27910 (919) 332-4137	Bertie, Gates Hertford, Northampton	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	46	0	B.A.	N/A	3	4	4	4	2
Mental Health Center (Cleveland County) 222 Crawford Street Shelby, NC 28150 (704) 482-8942	Cleveland	24 Hrs.	No	Yes	Yes	Yes	Yes	Yes M.D. Nurse	Yes	Yes	15	4	B.A. M.A.	-	5	3	8	9	50
Mental Health Center (Davidson County) 205 Old Lexington Road Thomasville, NC 27360 (919) 475-8184	Davidson	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	20	0	B.A.	N/A	10	7	7	11	12
Sandhills Center 303 E. View Street Wadesboro, NC 28170 (704) 694-6588	Anson	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes M.D. Nurse	Yes	No	3	0	-	N/A	5	2	2	20	4
Mental Health (Smoky Mountain Area) 1207 East Street Waynesville, NC 28786 (704) 456-9452	Haywood	24 Hrs.	Yes	Yes	No	Yes	Yes	Yes M.D. Nurse	Yes	No	8	0	M.A.	N/A	3-5	5	5	20	20
Mental Health Smokey Mountain P. O. Box 280 Dillsboro, NC 28725 (704) 586-5501	-	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M.D. Nurse	No	No	11	0	M.A.	N/A	5	20	15	15	5

*- indicates no response to the question.
***+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED													% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer	Immed Action	Crisis Housing	Health Care	Follow Up	Spec. Programs	No Prof.	No Vol.	Trng Prof.	Trng Vol			13-15	15-19	19-24	
Mental Health (Southeastern) 2023 S. 17th Street Wilmington, NC 28401 (919) 343-0151 (919) 763-3695 Crisisline	New Hanover Brunswick Pender	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	5	0	B.A.	N/A	3	45	20	0	1	
Mental Health Children's Service (Wilson-Greene) Wilson, NC 27893 (919) 399-8021	Wilson Greene	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes M.D. Nurse	Yes	No	3	30	M.A.	N/A	20	30	40	30	2	
New Horizons Group Home 807 Willow Street Hendersonville, NC 28739 (704) 692-0433	Henderson	24 Hrs.	No	No	Yes	No	Yes	No	Yes	Yes	3	0	B.A.	N/A	-	-	-	-	1 (for year)	
Pastoral Counseling Center-N. C. Baptist Hospital 300 S. Hawthorne Road Winston-Salem, NC 27103 (919) 748-3400	All	24 Hrs.	No	Yes	Yes	Yes	No	Yes M.D. Nurse	Yes	No	15	0	M.A.	N/A	10-25	15	10	20	40	
Personal & Family Counseling Cumberland County Dept. of Social Services 421 Maiden Lane Fayetteville, NC 28302 (919) 323-1540	Cumberland	24 Hrs.	Yes	Yes	Yes	Yes	No	No	No	No	5	5	M.S.W.	50 Hrs.	40	14	13	11	16	
Presbyterian Family Life Institute 229 Person Street Fayetteville, NC 28302 (919) 323-4525	Cumberland Robeson Harnett	10 Hrs. per day	No	Yes	Yes	Yes	No	Yes	No	Yes	1	0	M.A.	N/A	<5	10	15	20	1	
Department of Psychiatry/ Community Mental Health Service P. O. Box 141 Womack Army Community Hospital Ft. Bragg, NC 28307 (919) 396-3624	Cumberland Hoke Lee Harnett	24 Hrs.	No	Yes	Yes	Yes	Yes Atv. Duty	Yes M.D. Nurse	Yes	No	14	0	B.A.	N/A	15	2	5	50	50	
The Randolph Clinic, Inc. 100 Billingsley Road Charlotte, NC 28211 (704) 376-2431	Mecklenburg+	12 Hrs. 5 Days	No	Yes	Yes	Yes	No	Yes M.D. Nurse	No	Yes	16	0	M.A.	N/A	-	3	5	19	-	

*- indicates no response to the question.
**+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED								No. Prof.	No. Vol.	Trng Prof	Trng Vol	% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer.	Immed. Action	Crisis Housing	Health Care	Follow Up	Spec. Programs						13-15	15-19	19-24	
Real Crisis Intervention Inc. 312 E. 10th Street Greenville, NC 27834 (919) 758-HELP (4357	Pitt	24 Hrs.	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	16	13	H.S. Trng. Prog.	65	4	.3	6.6	13.2	16
The Relatives, Inc. 1000 E. Boulevard Charlotte, NC 28203 (704) 377-0602	Meckenburg**	24 Hrs.	Yes	Yes	Yes	Yes	Yes	No	Yes	No	8	0	B.A.	N/A	2	60	40	0	3
Respect, Inc. Rt. 6, Box 130 Macon, NC 27551 (704) 369-6143	Macon	24 Hrs.	Yes	Yes	Yes	Yes	Yes	Yes M.D. Nurse	Yes	No	1	12	M.A.	40 Hrs. +	5	1	1	20	3
Stress Management 4108 Park Road #212 Charlotte, NC 28209 (704) 523-1026	Mecklenburg	5 Days	No	No	Yes	Yes	No	No	No	No	1	0	M.A.	N/A	10%	combined	30		1
Suicide & Crisis Center of Alamance County, Inc. P. O. Box 2573 Burlington, NC 27215 (919) 228-1720	Alamance+	24 Hrs.	Yes	No	Yes	Yes	No	No	Yes	Yes	32	30	-	42 Hr. Trng.	50	combined	32		12-25
Surry Friends of Youth - Lifeline 150 N. Main Street Mt. Airy, NC 27030 (919) 789-9064 789-5344	Surry	5 Days	Yes	No	Yes	No	No	Yes	No	Yes	3	1	M.A.	10 Hrs.	10	35	35	15	2
Switchboard Crisis Center 330 S. Greene Street Greensboro, NC 27401 (919) 275-0896	Guilford+	24 Hrs.	Yes	Yes	Yes	No	No	No	No	No	35	32	-	41 Hrs.	4	3	9	20	18
Wake County Alcoholism Information Center 3824 Barrett Drive Suite 103 Raleigh, NC 27609 (919) 821-7515	Wake	24 Hrs.	Yes	Yes	Yes	Yes	No	No	No	Yes	3	45	Cert.	20 Hrs.	-	-	-	-	-

*- indicates no response to the question.
**+ indicates surrounding area.

TABLE V
SUICIDE-PREVENTION SERVICES IN NORTH CAROLINA

SERVICE	COUNTIES SERVED	HOURS	SERVICES OFFERED												% Suicide Related Services	% Age Ranges of Clientele			Suicide Related Cases Per Mo.
			Hot Line	Walk In	Refer.	Immed. Action	Crisis Housing	Health Care	Follow Up	Spec. Programs	No. Prof.	No. Vol.	Trng Prof.	Trng Vol.		13-15	15-19	19-24	
Henderson County Youth Services P.O. Box 1187 Hendersonville, N.C. 28793 (704)693-3353	Henderson	24	No	No	No	No	No	No	No	No	6	0	B.A.	70	-	-	-	-	0
Youth Care, Inc. 211 S. Edgeworth St. Greensboro, N.C. 27401 (919)378-9109	Guilford	24 Hrs.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	10	0	M.A.	N/A	1	20	80	0	2
Triangle Youth For Christ 3700 Western Blvd. Raleigh, NC 27606 (919) 832-0388	Wake Durham Orange+		No	Yes	No	Yes	No	No	No	No	30	30	B.A.	70 Hrs.	-	-	-	-	4
Youth & Family Counseling Service 203 W. 2nd Street Lexington, NC 27292 (704) 249-0237	Davidson	5 Days	No	No	Yes	Yes	No	Yes	Yes	Yes	4	7	B.A.	18 Hrs.	30	50	20	1	3
Rutherford County Youth Services, Inc. 617 N. Main Street Rutherford, NC 28139	Rutherford McDowell Polk	24 Hrs.	No	No	No	No	No	No	Yes	Yes	3	0	B.A.	N/A	1	80	10	0	0
Youth Unlimited, Inc. P. O. Box 485 High Point, NC 27261 (919) 883-1361	Guilford-Randolph	24 Hrs.	No	Yes	Yes	Yes	No	No	No	No	1	-	-	N/A	3	60	30	10	1

*- indicates no response to the question.
**+ indicates surrounding area.

orientation of the facility. Some facilities served only youth while others were adapted to the adult population. Many respondents indicated that this information was not available.

Survey participants were also asked to estimate the number of suicide-related cases handled by staff per month. The responses varied among facilities with the majority indicating less than 10.

Services available from respondents were publicized in a number of ways. The most popular means included telephone directories, newspapers, radio, television, billboards, brochures and community presentations.

Discussion

It would be remiss to attempt an across-the-board comparison in this document of the suicide prevention/intervention services participating in this survey. The intent here is to assess the availability and type of services offered to young people in the state. A much more exhaustive study is needed to ascertain the quality of services and, if possible, the impact of these facilities on the suicide rate. What is illustrated here is a network of suicide-prevention facilities administering services at a variety of levels to the local and, in some cases, state population. Obviously, there are some concerns which become immediately apparent.

Twenty-five percent of the sample indicated that there had been a cut in funds earmarked for services and 10 percent indicated no change over a five-year period. To mount any sustained effort at curbing the current rate of teenage suicide requires not only resources but more efficient use of available funds.

Another question that the data raised has to do with the percentage of overall services related to suicide prevention. More than half of those responding to this question indicated that 5 percent or less of total services involved this component. While one must look at the overall scope of the facility, if such little emphasis is put on suicide prevention it stands to reason that the community and, in particular, young people, may not perceive this as a legitimate part of the services.

The services afforded potential suicides among the sample appear to be varied and largely dependent upon the overall purpose of the facility. Of extreme importance is the 24-hour availability which almost 90 percent of the respondents indicated they had. Nonetheless, there was a noticeable sparsity in crisis housing and special programs for adolescents.

Overall, 70 percent of the counties in North Carolina were covered by one of the facilities participating in the survey. While a few indicated that they served the whole state, it is probable that there are similar facilities in the other 30 percent of the counties or areas which did not have a respondent to the questionnaire. It appears from this survey that services are in place and at least accessible to persons in need of help throughout the state. Further study is needed to assess the quality of services and the perceptions of young people and the community at large regarding what these services have to offer in the way of suicide prevention/intervention.

CONCLUSION

Teenage suicide is a calamity that cuts across all boundaries - gender, race, social/economic class and geographic region. As a result, the efforts organized for prevention and intervention must be just as wide-ranging and varied. If the present course is to be changed, effort is needed from all segments of the community including teenagers and their families, schools, churches, community organizations and medical personnel as well as mental health professionals and volunteers. Help is also needed from city, state and federal officials and statewide and national organizations concerned with the development and well-being of youth.

A first line of defense against increased suicidal behavior is dependent upon teenagers being properly educated about the pressures and tensions of adolescence. They must also be taught coping skills with an emphasis on how to handle grief and failure. Parents and teachers should impress upon young people that they are loved unconditionally and encourage them to take small steps to reach their goals and aspirations. However, when tension does mount or depression sets in, teenagers must be taught to communicate their feelings to someone without shame. They must be able to identify the services and programs in the community that can help them with their problems or help a friend with his/her problems. The awareness of teenagers is a crucial element in bringing about a decline in suicides.

At another level but just as important is the awareness of parents, teachers, counselors, medical doctors and youth service workers. They must be aware of the variety of suicidal behavior displayed by young people and the sometimes conflicting symptoms emitted when teenagers are depressed. Parents and teachers, especially, must be taught to look beyond the acting out and delinquency behavior which may manifest serious underlying causes that yelling and punishment cannot treat. Since nine out of 10 suicide attempts take place in the home, parents need to be aware that this is where suicidal adolescents are at greatest danger. Parents need to know what to do and where to get help.

Studies show that many teenagers are examined by their doctors before committing suicide because they complain of not feeling well. In many instances, the doctors have found them to be physically fit but failed to ask their patients about problems that could be causing mental stress. Doctors, too, must be made aware of the symptoms of teenage depression and how they can act responsibly by making sure that proper referrals are made.

Teenagers, parents, teachers and others are dependent upon the mental health professionals and volunteers in the community to prepare them with the knowledge and skills necessary to act appropriately prior to and during a crisis situation. It is encumbered upon the staffs of suicide-prevention facilities, mental health centers and hospitals to offer the needed training through classes and workshops to present the facts about suicide and its symptoms, steps to take when dealing with suicidal behavior and the availability of services in the community. Mental health professionals and volunteers must develop and maintain a working relationship with school, churches and other agencies and organizations serving youth to ensure that their staffs are well-informed regarding the stress factors contributing to suicidal behavior and how to prepare adolescents to cope. They must also make

themselves available as consultants to help deactivate crisis situations in the schools and other community programs.

City, county and state governments must ensure that services are provided to address the concerns of youth. Money should be provided to establish crisis centers and hotlines and also to ensure that programs and services for the positive development and well-being of young people are developed and maintained. Social and educational programs that will enhance the self-esteem and coping skills of young people should be encouraged.

Finally, state government through the Department of Human Resources should join with the National Institute of Mental Health to foster research that will demonstrate the effectiveness of hotlines and crisis centers. Another focus of the research should be to develop standards for crisis centers in regard to organization, staffing, training, ethics, services and program evaluation.

NOTES

1. Published Data, Division of Vital Statistics, National Center for Health Statistics.

2. Detailed Mortality Statistics Reports, North Carolina, State Center for Health Statistics.

3. V.M. Victoroff, The Suicidal Patient (Qradell, N.J.: Management Medical Economic Books, 1983), p. 9.

4. P. Bosworth, "Let's Call It Suicide," Vanity (March 1985), p. 54.

5. B.J. Silver, S.E. Golston and L.B. Silver, "The 1990 Objectives for the Nation for Control of Stress and Violent Behavior: Progress Report," Public Health Reports (July - August 1984), p. 375.

6. C.L. Tishler, P.C. McKenry and K.C. Morgan, "Adolescent Suicide Attempts: Some Significant Factors," Suicide and Life-Threatening Behavior (Summer 1981), p. 87.

7. M. Czikszentmihalyi and R. Lawson, Being Adolescent (N.Y.: Basic Books, Inc., 1984), p. 16.

8. M. Weiss, "The Riddle of Teenage Suicide," Ladies Home Journal (June 1984), p. 171.

9. Ronald Maris Interview, "Why 30,000 Americans Will Commit Suicide This Year," U.S. News and World Report, Inc. (April 2, 1984), p. 48.

10. M.A. O'Roard, "The Alarming Rise in Teenage Suicide," McCall's (January 1982), p. 16.

11. C. Luty, "The Language of Desperation," Today's Education (1982-83 Annual), p. 57.

12. A. Mackey, "The Frightening Facts About Teen Suicide," Teen (October 1983), p. 12.

13. H. Hendin, Suicide in America (N.Y.: Norton and Company, 1982) p. 39.

14. C. Luty, p. 58.

15. Ibid.

16. C.L. Tishler, P.C. McKenry and K.C. Morgan, p. 91.

17. Ibid.

18. Ibid.

19. Ibid.

20. M. Marshall, "Teenage Suicide: Why Our Children Are Killing Themselves," Ebony (September 1981), p. 16.

21. F. Klagbrun, Too Young To Die: Youth and Suicide (Boston: Houghton Mifflin Co., 1976), p. 15.

22. H. Hendin, p. 30.

BIBLIOGRAPHY

Books

Battin, M.P. and D.J. Mayo. Suicide: The Philosophical Issues. New York: St. Martin's Press, 1980.

Csikszentmihalyi, M. and R. Larson. Being Adolescent. New York: Basic Books, Inc., 1984.

Farberow, Norman. Suicide in Different Cultures. Baltimore: University Park Press, 1975.

Finch, Stuart M. and E.O. Poznanski. Adolescent Suicide. Springfield, Illinois: Charles C. Thomas, 1971.

Fisher, Shelia A. Suicide and Crisis Intervention. New York: Springer Publishing Co. Inc., 1973.

Giovacchini, P. The Urge To Die: Why Young People Commit Suicide. New York: MacMillan Publishing Co. Inc., 1981.

Hatton, C.L. and S.M. Valente. Suicide: Assessment and Intervention. Norwalk, Connecticut: Appleton-Century-Crofts, 1984.

Hankoff, L.D. and B. Einsidler. Suicide: Theory and Clinical Aspects. Littleton, Massachusetts: PSG Publishing Co. Inc., 1979.

Hendin, H. Suicide in America. New York: Norton and Co., 1982.

Jacobs, J. Adolescent Suicide. New York: Irvington Publishers, Inc., 1980.

McIntosh, J.L. and J.F. Santos. Suicide Among Children, Adolescents and Students: A Comprehensive Bibliography. Public Administration Series. Monticello, Illinois: Vance Bibliographies, 1981.

Mars, Ronald W. Pathways to Suicide: A Survey of Self-Destructive Behaviors. Baltimore: The John Hopkins University Press, 1981.

Motto, J.A., R.M. Brocks, C.P. Ross and N.H. Allen. Standards for Suicide Prevention Crisis Centers. New York: Behavioral Publications, 1974.

Parker, A. Suicide Among Young Adults. New York: Exposition Press, 1974.

Syed, A.H. and T. Vandiver. Suicide in Children and Adolescents. New York: Spectrum Publications, Inc., 1984.

Victoroff, V.M. The Suicidal Patient: Recognition, Intervention, Management. Oradell, New Jersey: Medical Economic Books, 1983.

Articles and Pamphlets

Bosworth, Patricia. "Let's Call It Suicide," Vanity, March 1985, pp. 52-110.

Cole, George H. "Suicide in America," Readers' Digest, January 1984, pp. 96-100.

Comer, J.P. "Young Suicides," Parents, August 1982, p. 88.

Fields, Kim. Testimony Before House Select Committee on Children, Youth and Families, October 27, 1983.

Freese, Arthur. Adolescent Suicide: Mental Health Challenge, Public Affairs Pamphlet No. 569, The Public Affairs Committee, 1979.

Griffin, Mary. Testimony Before House Select Committee on Children, Youth and Families, October 27, 1983.

Jurnovoy, Joyce and David Jenness. "Teenage Suicide," Good Housekeeping, July 1984, pp. 86-94.

Luty, Carl. "The Language of Desperation," Today's Education, 1982-83 Annual, pp. 57-59.

Mackey, Aurora. "The Frightening Facts about Teen Suicide," Teen, October 1983, pp. 10-94.

Maris, Ronald. Interview. "Why 30,000 Americans Will Commit Suicide This Year," U.S. News and World Report, April 2, 1984, pp. 48-50.

Marshall, Marilyn. "Why Our Children Are Killing Themselves," Ebony, September 1981, pp. 36-38.

Orbach, I., Yiegal Gross and H. Glaubman. "Some Common Characteristics of Latency-Age Suicidal Children: A Tentative Model Based on Case Study Analyses," Suicide and Life Threatening Behavior, Fall 1981, pp. 180-190.

O'Roark, Mary Ann. "The Alarming Rise in Teenage Suicide," McCalls, January 1982, pp. 14-120.

Pfeffer, C.R. "Interventions for Suicidal Children and Their Parents," Suicide and Life Threatening Behavior, Winter 1982, pp. 240-248.

Silver, B.J., S.E. Goldston and L.B. Silver. "The 1990 Objectives for the Nation for Control of Stress and Violent Behavior: Progress Report," Public Health Reports, July-August 1984, pp. 374-384.

Smith, Judie. Testimony Before House Select Committee on Children, Youth and Families, October 27, 1983.

Thornton, Jeannye. "Behind a Surge in Suicides of Young People," U.S. News and World Report, June 20, 1983, p. 66.

Tishler, C.L., P.C. McKenry and K.C. Morgan. "Adolescent Suicide Attempts: Some Significant Factors," Suicide and Life Threatening Behavior, Summer 1981, pp. 86-92.

Topol, P. and M. Reznikoff. "Perceived Peer and Family Relationships, Hopelessness and Locus of Control as Factors in Adolescent Suicide Attempts," Suicide and Life Threatening Behavior, Fall 1982, pp. 141-150.

Weiss, M. "The Riddle of Teenage Suicide," Ladies Home Journal, June 1984, pp. 54-172.

Governor's Advocacy Council on Children and Youth

121 W. Jones St.
Raleigh, N. C. 27603

919/733-9296

Herb Stout
Raleigh, Chairman #

Linda Garrou
Winston-Salem,
Vice Chairman #

Leslie Anderson
Asheville #
Richard C. Brake
Gastonia
Anne Belk Davis
Monroe
Eva Marie Dees
Robbinsville
Betty Hinson
Greensboro
Carter C. Holloman
Alberson
Rep. Wahee R. Jones
Lumberton
Sen. Helen Rhyne Marvin
Greensboro
John R. Peacock
Fremont
Hugh P. [illegible]
Rockingham
[illegible]
[illegible]
Lisa Sell
Southport #
Sen. Luta S. Tally
Fayetteville
Rep. Tom Womble
Clemmons
Halina Zaytoun
Cary

Member, Executive Committee

July 5, 1984

MEMORANDUM

TO: Providers of Suicide Prevention and Intervention Services

FROM: Herb Stout

RE: Survey of Services

The Governor's Advocacy Council on Children and Youth is presently conducting a study on teenage suicide in North Carolina. One focus of the study is the availability of prevention and intervention services across the state to deal with this problem. To gather this information we have developed a brief survey to be filled out by providers of suicide related services. Your organization has been identified as one of these providers.

It would be a tremendous help to us if you filled out the enclosed form and returned it to us by July 23, 1984. Your support is very much appreciated.

If you have any questions, please contact Maria Morse at 733-9296.

BEST COPY AVAILABLE

A SURVEY OF SUICIDE PREVENTION SERVICES IN NORTH CAROLINA

Directions: Check all that apply.

Name of Service _____

Address _____ Telephone No. _____

Name of counties served _____

Sources of Funding:

Federal Government ☐ State Government ☐

Private Grants ☐ Charitable Organizations ☐

Church Group(s) ☐ Other ☐ Specify _____

Over the past 5 years, has your services budget ☐ increased, ☐ decreased or ☐ remained the same?

What percentage of your services is suicide prevention/intervention related? _____

Approximately how many suicide related cases does your staff handle per month? _____

How many service level/counseling persons do you have on your staff? _____

How many are paid? _____ How many are volunteers? _____

What are the educational requirements for service level/counseling staff? _____

_____

How many hours of training are required for the volunteer staff? _____

What are the hours of operation for your suicide prevention/intervention services?

24 hours per day ☐ Less than 24 hours per day ☐ Specify _____

7 days per week ☐ Less than 7 days per week ☐ Specify _____

Does your service provide:

Immediate Action ☐ Referral Service ☐

Walk-in ☐ Hotline ☐

How are your services advertized? _____

BEST COPY AVAILABLE

What percentage of your clientele falls within these age ranges?

13 - 15 year olds / 7

15 - 19 year olds /☐

19 - 24 year olds /☐

How long has this service been offered? _____

Does your service provide:

Health Care (i.e. Physician, Nurse) /☐ Short-term Crisis Housing /☐

Mental Health Care /☐

Follow-up /☐ Specify _____

Special Programs for Adolescents /☐ Specify _____

If there are additional comments you would like to make, please use the space below or an attachment if necessary.

Name of Contact Person _____

Brochures Enclosed Yes /☐ No /☐

PLEASE RETURN THIS FORM BY JULY 23, 1984 to Maria Morse, Youth Advocacy and Involvement Office, 121 West Jones Street, Raleigh, North Carolina 27611

IF YOU WOULD LIKE A COPY OF THE FINAL DOCUMENT PLEASE CONTACT ME AT THE ABOVE ADDRESS

APPENDIX B

ORGANIZATIONS CONCERNED WITH SUICIDE

***10197* AMERICAN ASSOCIATION OF SUICIDOLOGY (Suicide) (AAS)**
2459 S. Ash Phone: (303) 692-0985
Denver, CO 80222 Julie Perlman, MSW, Exec. Officer
Founded: 1967. **Members:** 650. Psychologists, psychiatrists, social workers, nurses, health educators, physicians, directors of suicide prevention centers, clergy, and others "from various disciplines and fields of experience who share a common interest in the advancement of studies of suicide prevention and life-threatening behavior." Seeks to recognize and encourage suicidology (the study of suicide, suicide prevention and related phenomena of self-destruction). Advances education, disseminates knowledge through programs and publications, and cooperates with other organizations in suicidology. Bestows awards. **Publications:** (1) Newslink, quarterly; (2) Suicide and Life Threatening Behavior, quarterly; (3) Proceedings of Annual Meeting; also publishes directory of current suicide prevention centers in U.S.A. **Affiliated with:** International Association for Suicide Prevention. **Convention/Meeting:** annual - 1985 April or May, Toronto, ON, Canada.

***10198* INSTITUTE FOR STUDIES OF DESTRUCTIVE BEHAVIORS AND THE SUICIDE PREVENTION CENTER OF LOS ANGELES**
1041 S. Menlo Ave. Phone: (213) 386-5111
Los Angeles, CA 90006 Norman L. Farberow, Ph.D., Co-Dir.
Founded: 1958. **Staff:** 90. Professionally-staffed center established for the evaluation, referral, treatment, follow-up, and over-all prevention of suicidal behavior. Conducts research on causes of suicide, symptoms of suicide intent, and techniques for aiding potential suicides. Sends suicide prevention information to doctors, clergymen, policemen, and others throughout the country. Offers periodic training institutes, conducts workshops throughout the country, gives lectures, and employs a variety of media, including books, brochures, technical articles, and films. Offers counseling and recreation services for youths. Maintains liaison with social and governmental agencies; works with the county coroner's office to conduct "psychological autopsies," investigations of equivocal cases of death in order to clarify the victim's intention as related to his own death. Also treats and conducts research on drug addiction, alcoholism, and related problems. The center was organized with funds from the U.S. Public Health Service, but now operates with local government and community support. Maintains a methadone maintenance clinic composed of a maintenance component and a detoxification component. **Affiliated with:** International Association for Suicide Prevention; World Federation for Mental Health. **Convention/Meeting:** biennial.

***10199* INTERNATIONAL ASSOCIATION FOR SUICIDE PREVENTION (IASP)**
c/o Charlotte P. Ross
Suicide Prevention and Crisis Center
1811 Trousdale Dr. Phone: (415) 877-5604
Burlingame, CA 94010 Charlotte P. Ross, Sec.Gen.
Founded: 1960. **Members:** 950. **Staff:** 1. Individuals and societies regularly engaged in suicide research and/or prevention activities. Societies may become members only when two members of their staff are regular members of IASP. Membership is worldwide, with association headquarters in Vienna, Austria. Goals include the establishment of an organization where individuals and agencies of various disciplines and professions from different countries can find a common platform for interchange of acquired experience, literature and information about suicide. Disseminates information about suicide prevention to professional and public resources; arranges for specialized training of persons in suicide prevention; encourages and carries out research programs, especially those that can be pursued through international joint cooperation. Presents the Erwin Stengel Award to an individual for outstanding contributions to the field of suicide prevention. **Publications:** Crisis, quarterly. **Affiliated with:** World Federation of Mental Health. **Convention/Meeting:** biennial - 1985 Vienna, Austria; 1987 San Francisco, CA.

***10200* NATIONAL SAVE-A-LIFE LEAGUE (Suicide) (NSLL)**
4520 Fourth Ave., Suite MH3 Phone: (212) 492-4067
New York, NY 11220 Joseph S. Lowenstein, Pres.
Founded: 1906. Professionals and trained volunteers. Activities are directed toward the prevention of suicide and to the families of suicide victims. Maintains a central crisis center offering counseling; provides speakers to bring the problem of suicide to national attention; sponsors production of radio programs designed to educate the public and reach those contemplating suicide; maintains emergency telephone hot line (see telephone number above) to provide voluntary aid to those in distress; places advertisements publicizing the work of the league and the hot line number; sends children of suicide victims to camp; works in close cooperation with the more than 100 crisis centers across the United States; offers financial aid and referrals.

***10202* THE SAMARITANS (Suicide)**
802 Boylston St. Phone: (617) 247-0220
Boston, MA 02199 Shirley Karnovsky, Exec.Dir.
Founded: 1974. **Members:** 150. **Staff:** 4. **Regional Groups:** 7. People who volunteer their time to befriend the suicidal, the despairing, and the lonely. Maintains 24-hour emergency telephone service and daily walk-in service for suicidal and depressed people. Has founded "Lifeline," a suicide intervention program, in Boston, MA area jails using a team of trained inmates to spot and befriend potential suicides in jail. Holds over 100 talks and training workshops annually for professionals and lay people on suicide prevention. Provides information on suicide and suicide prevention. Not a religious organization.

***10203* SEASONS: SUICIDE BEREAVEMENT, INC.**
4777 Naniloa Dr. Phone: (801) 272-0438
Salt Lake City, UT 84117 Christina Valentine Bird, Pres.
Founded: 1981. **Staff:** 2. **State Groups:** 5. **Local Groups:** 7. A support group of families and individuals united to bring together survivors of a person who has committed suicide so they may help each other develop a healthy understanding of their loss and grief, and work toward recovery. Objective is to provide self-help for the survivors of a suicide victim by putting them in contact with others who are dealing or have dealt with similar situations and emotions. Offers a place to discuss difficult issues; provides an opportunity to benefit from others' experiences in coping with a suicide; and offers information and referrals. Sponsors monthly meetings, lectures, training seminars, and media presentations. Conducts children's services. Maintains 200 volume library of books, videotapes on grief and suicide, and suicide prevention educational materials. **Publications:** Seasons Newsletter, monthly.

SOURCE: Encyclopedia of Associations
1985
19th edition

Excerpted from ENCYCLOPEDIA OF ASSOCIATIONS: 1985, edited by Denise S. Akey (copyright © 1959, 1961, 1964, 1968, 1970, 1972, 1973, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984 by Gale Research Company; reprinted by permission of the publisher), nineteenth edition, Gale Research, 1984.

BEST COPY AVAILABLE

APPENDIX C

DEPARTMENT OF PUBLIC INSTRUCTION

STATE OF NORTH CAROLINA RALEIGH

MEMORANDUM June 18, 1984

TO: Maria Morse

FROM: Bob Frye

RE: Suicide Prevention

You asked for a summary of what public schools are doing in suicide prevention programming. As I explained on the phone, we don't really have a state adopted or suggested suicide prevention program. And, even if we did, it would be up to each local school system to determine whether to use it.

I am not at all sure that I would favor each school having a suicide prevention program. Although suicide is the third leading cause of death among 15 to 24 year olds, and although the suicide rate, especially among males, has increased considerably in this age group during the last several years, I am troubled by the negativism of pregnancy prevention programs, drug abuse prevention programs, child abuse prevention programs, suicide prevention, stress prevention, violence prevention, drop out prevention, etc.

I favor an approach that uses a solid, broad-based, continuous, sequential curriculum that develops self-concept, enhances decision-making and conflict resolution skills, creates an attitude of responsibility for oneself and ones actions, prepares students to recognize and deal with their own emotions on a daily basis and in crisis situations (e.g. death, fear, infatuation) enables students to develop interpersonal and group communication skills (e.g. active listening, expressing feelings), establishes self-assessment and behavior change skills, helps students learn to develop support systems, develops goal-setting skills, and so forth.

In the course of such a comprehensive curriculum, topics such as suicide, drug abuse, sexual activity, and so forth would occur naturally (and be planned for) in the learning and practicing of skills. I think this is a much better way to deal with the health-related problems of teenagers than trying to provide special programs for each of the potential multitude of specific problems. These special programs seldom seem to be coordinated or lasting.

In combination with such a curriculum, students would have access to professional guidance services to help them deal with problems they are unable to handle themselves. Non-professional peer counseling services

are also a great asset. Students should also be aware of the many community services available to them for special problems (e.g. "hot line", clinics, support groups such as Al-Anon).

We have some publications that approach the sort of curriculum I described, but we don't really have a comprehensive curriculum and program available to schools at this point. Some of these publications include:

- Life Skills for Health: Focus on Mental Health (K-12)
- Comprehensive Health Education Curriculum (K-12)
- Resource Manual for Guidance

I will be on vacation for most of the next four weeks; so, if you need any further information within that time, you might call my colleague, George Shackelford. His phone number is the same as mine, 733-3906.

BF/pho

cc: Ron Anderson
George Shackelford

North Carolina Department of Administration
1,000 copies of this public document were printed
at a cost of $788.70 or $.79 per copy